



Flexible Spending Account
Enrollment Agreement
_____ Plan Year

I wish to have my salary redirected for the period _____ through _____ in each of the categories below. I understand the benefits available to me as well as the other rights and obligations that I have under the Plan. I understand this agreement revokes any prior election under this plan and that during the above period this agreement is irrevocable and cannot be changed except under special circumstances as outlined in the Summary Plan Description. This agreement is subject to the terms of State of Nebraska Flexible Spending Account Plan.

Social Security Number _____/_____/_____

Name _____
(Last, First MI)

Street _____

City _____
State, Zip _____

	Per Pay Period	# of Pay Periods	Total for the Plan Year	Not to Exceed
--	-------------------	---------------------	----------------------------	------------------

Health Care Reimbursement Account	_____	_____	_____	\$3,000.00
-----------------------------------	-------	-------	-------	------------

Dependent Care Assistance Account (Cannot exceed \$416.66 per month)	_____	_____	_____	\$5,000.00
---	-------	-------	-------	------------

☐ I hereby acknowledge the opportunity to participate in the flexible spending accounts. I understand that by not participating at this time, I will only be allowed into the plans at the next Open Enrollment period or if I have a qualified status change as defined by the Plan.

DIRECT DEPOSIT REIMBURSEMENT (Flexible Spending Accounts only)

I authorize ASI to credit my _____ (checking, savings) account number _____ at (name of bank) _____, with my Flexible Spending Account payments. Please attach a copy of a check or a void check and write the bank's routing number _ _ _ _ _.

E-MAIL

_____ I wish to receive my notification of direct deposit reimbursement via e-mail at the address below instead of U.S. Mail.

E-mail address: _____

Employee's signature: _____

Date _____

1-800-659-3035
email: asi@asiflex.com
<http://www.asiflex.com>